STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N046057	A. BUILDING: _____ B. WING _____	C 02/21/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ABERDEEN VILLAGE	17500 WEST 119TH STREET OLATHE, KS 66061

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S 000	INITIAL COMMENTS The following citations represent the findings of Complaint Investigation KS#72031.	S 000		
S3081 SS=D	26-41-201 (c) Functional Capacity Screen Reassessment (c) Designated facility staff shall conduct a screening to determine each resident ' s functional capacity according to the following requirements: (1) At least once every 365 days; (2) following any significant change in condition as defined in K.A.R. 26-39-100; and (3) at least quarterly if the resident receives assistance with eating from a paid nutrition assistant. This REQUIREMENT is not met as evidenced by: K.A.R. 26-41-201 (c)(2) The facility reported a census of 35 residents and the sample included 3 residents. Based on observation, record review, and interview, the facility failed to update and revise the functional capacity screen after a significant change of condition as required for 1 resident (#1) of the sample. Findings included: - According to the clinical face sheet, the facility admitted resident #1 on 12/31/13. Review of the physician's order sheet dated 1/1/14 recorded the diagnosis of dementia (a progressive mental disorder characterized by failing memory and confusion).	S3081		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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S3081	Continued From page 1 Review of the Resident Functional Capacity Screen dated 12/31/13 documented the resident required supervision for bathing, had short-term memory problem, problem with memory/recall and impaired decision making. Interdisciplinary notes dated 1/14/14 timed 6:25 A.M., documented staff responded to the east patio door alarm that sounded at 4:55 A.M. and found the resident missing from his/her recliner in his/her room. At approximately 5:15 A.M., a local police officer found the resident at a local business and notified the facility. Observation on 2/19/14 at 1:15 P.M. revealed the resident walked slowly down the hallway following his/her spouse to their apartment. On 2/19/14 at 1:20 P.M., direct care staff O reported that sometimes the resident's spouse would request staff help to lay the resident down and change his/her clothing or brief. Direct care staff N reported staff placed a special door alarm on the inside of the resident's room after he/she eloped to alert staff if the resident opened the apartment door. On 2/20/14 at 9:35 A.M., licensed nursing staff H revealed staff did not complete a screening for the resident's functional capacity after the resident eloped from the facility. Review of the facility provided policy Resident Functional Capacity Screen dated February 1997 directed staff to screen the functional capacity after a significant change in condition, which necessitated an amendment of the negotiated service agreement. Section III of the assessment recorded the purpose of the assessment was to	S3081		

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S3081	Continued From page 2 identify current or recent problems and risks which at the time of the screen affected the resident's functional capacity and included a section for wandering. The facility failed to update and revise the functional capacity screen after this resident's wandering resulted in his/her elopement from the facility.	S3081		
S3092 SS=D	26-41-202 (d) Negotiated Service Agreement Revisions (d) Each administrator or operator shall ensure the review and, if necessary, revision of each negotiated service agreement according to the following requirements:(1) At least once every 365 days; (2) following any significant change in condition, as defined in K.A.R. 26-39-100; (3) at least quarterly, if the resident receives assistance with eating from a paid nutrition assistant; and (4) if requested by the resident or the resident ' s legal representative, facility staff, the case manager, or, if agreed to by the resident or the resident ' s legal representative, the resident ' s family. This REQUIREMENT is not met as evidenced by: K.A.R. 26-41-202 (d) (2) The facility identified a census of 35 residents with 3 residents in the sample. Based on observation, interview, and record review the facility failed to revise the Negotiated Service Agreement (NSA) to reflect the changes in care	S3092		

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S3092	Continued From page 3 for 1 resident (#1) after an elopement from the facility and spouse required hospitalization. Findings included: - According to the clinical face sheet, the facility admitted resident #1 on 12/31/13. Review of the physician's order sheet dated 1/1/14, recorded the diagnosis of dementia (a progressive mental disorder characterized by failing memory and confusion). Review of the Resident Functional Capacity Screen dated 12/31/13 documented the resident required supervision for bathing, had short-term memory problem, problem with memory/recall, and impaired decision making. Review of the NSA dated 12/31/13 documented the resident with a Wanderguard alarm to alert staff if he/she got close to exits; the resident's spouse was with the resident the majority of the time; and the resident's spouse would order, store, and administer the resident's medications. Interdisciplinary note dated 1/14/14 timed 6:25 A.M., documented staff responded to the east patio door alarm that sounded at 4:55 A.M. and found the resident missing from his/her recliner in his/her room. At approximately 5:15 A.M., a local police officer found the resident at a local business and notified the facility. Interdisciplinary note dated 1/14/14 timed 10:31 P.M., recorded a caregiver arrived to stay with the resident and spouse until the morning. Staff oriented the caregiver to the alarm on the door, pendant alert system, and to the resident and his/her spouse.	S3092		

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S3092	Continued From page 4 Interdisciplinary note dated 1/26/14 timed 1:55 P.M., documented the resident was aware his/her spouse was taken to the hospital at this time. Staff would ensure care was given in the spouse's absence. The family arranged a home health care giver to sit with the resident from 8 P.M. to 8 A.M. Interdisciplinary note dated 1/26/14 at 9:52 P.M., recorded the resident had a private caregiver present at this time and staff would monitor. Interdisciplinary note dated 1/29/14 timed 10:56 A.M., recorded staff gave report to the visiting nurses who would provide private duty care from 7:30 A.M. to 7:30 P.M. The NSA lacked evidence of revisions to reflect the changes in care regarding the care provided by visiting nurses, private duty sitters, or the times of the care. Observation on 2/19/14 at 1:15 P.M. revealed the resident walked slowly down the hallway following his/her spouse to their apartment. On 2/19/14 at 1:20 P.M., direct care staff O reported that sometimes the resident's spouse would request staff help to lay the resident down and change his/her clothing or brief. Direct care staff N reported staff placed a special door alarm on the inside of the resident's room after he/she eloped, to alert staff the resident opened the apartment door. On 2/20/14 at 9:35 A.M., licensed nursing staff H reported, when the resident's spouse was out of the facility in the hospital, facility nurses took the medications out of the resident's apartment and	S3092		

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S3092	Continued From page 5 administered the medications. Licensed nursing staff H revealed staff did not revise/complete a new Functional Capacity Screen or Negotiated Service Agreement. Review of the facility provided policy NSA dated August 2012 directed staff to review and revise the NSA after each significant change in the resident. The NSA would include the services to be provided, how the services would be provided by the facility and outside agency, coordinated by the facility, how often, and when the services would be provided. The facility failed to revise the NSA to reflect the change of care and services for this resident after a significant change in condition.	S3092		
S3170 SS=D	26-41-204 (g) (h) Health Care Services (g) Skilled nursing care shall be provided in accordance with K.S.A. 39-923 and amendments thereto. (1) The health care service plan shall include the skilled nursing care to be provided and the name of the licensed nurse or agency responsible for providing each service. (2) The licensed nurse providing the skilled nursing care shall document the service and the outcome of the service in the resident ' s record. (3) A medical care provider ' s order for skilled nursing care shall be documented in the resident ' s record in the facility. A copy of the medical care provider ' s order from a home health agency or hospice may be used. Medical care provider orders in the clinical records of a home health agency located in the same building as the facility may also be used if the clinical records are available to licensed nurses and direct care staff	S3170		

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S3170	Continued From page 6 of the facility. (4) The administrator or operator shall ensure that a licensed nurse is available to meet each resident ' s unscheduled needs related to skilled nursing services. (h) A licensed nurse may provide wellness and health monitoring as specified in the resident ' s negotiated service agreement. (i) All health care services shall be provided to residents by qualified staff in accordance with acceptable standards of practice This REQUIREMENT is not met as evidenced by: K.A.R. 26-41-204 (g) (1) The facility reported a census of 35 residents and the sample included 3 residents. Based on observation, record review, and interview the facility failed to revise the Health Care Services Plan (HCSP) to reflect the skilled nursing care services provided for 1 (#1) resident of the sample. Findings included: - According to the clinical face sheet, the facility admitted resident #1 on 12/31/13. Review of the physician's order sheet dated 1/1/14, recorded the diagnosis of dementia (a progressive mental disorder characterized by failing memory and confusion). Review of the Resident Functional Capacity Screen dated 12/31/13 documented the resident required supervision for bathing, had short-term	S3170		

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S3170	Continued From page 7	S3170		

memory problem, problem with memory/recall and impaired decision making.

Review of the Negotiated Service Agreement (NSA) dated 12/31/13, documented the resident with a Wanderguard alarm to alert staff if he/she was close to an exit; the resident's spouse was with the resident the majority of the time; and the resident's spouse would order, store, and administer his/her medications.

Review of the HSCP dated 12/31/13 directed:
Personal care, the resident was still independent with his/her activities of daily living, but his/her spouse kept a watchful eye due to his/her dementia. The resident usually awakened between 7 A.M. and 8 A.M., and then went to the restroom; showered daily along with shaving. The resident wore incontinence pull-ups as he/she sometimes had dribbling or occasional incontinence at night. The resident's spouse bagged soiled incontinence products after the resident took them off.
Medication Management, spouse administered, ordered and stored the resident's medications.
Skilled nursing procedures: monthly vital signs.

Interdisciplinary note dated 1/14/14 timed 6:25 A.M., documented staff responded to the east patio door alarm that sounded at 4:55 A.M. and found the resident missing from his/her recliner in his/her room. At approximately 5:15 A.M., a local police officer found the resident at a local business and notified the facility.

Interdisciplinary note dated 1/14/14 timed 10:31 P.M., recorded a caregiver arrived to stay with the resident and spouse until the morning. Staff oriented the caregiver to the alarm on the door, pendant alert system, and to the resident and

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S3170	Continued From page 8 his/her spouse. Interdisciplinary note dated 1/26/14 timed 1:55 P.M., documented the resident was aware his/her spouse was taken to the hospital at this time. Staff would ensure care was given in the spouse's absence. The family arranged a home health care giver to sit with the resident from 8 P.M. to 8 A.M. Interdisciplinary note dated 1/26/14 at 9:52 P.M., recorded the resident had a private caregiver present at this time and staff would monitor. Interdisciplinary note dated 1/29/14 timed 10:56 A.M., recorded staff gave report to the visiting nurses who would provide private duty care from 7:30 A.M. to 7:30 P.M. Observation on 2/19/14 at 1:15 P.M. revealed the resident walked slowly down the hallway following his/her spouse to their apartment. On 2/19/14 at 1:20 P.M., direct care staff O reported that sometimes the resident's spouse would request staff help to lay the resident down and change his/her clothing or brief. Direct care staff N reported staff placed a special door alarm on the inside of the resident's room after he/she eloped to alert staff the resident had opened the apartment door. On 2/20/14 at 9:35 A.M., licensed nursing staff H reported, when the resident's spouse was out of the facility in the hospital, facility nurses took the medications out of the resident's apartment and administered the medications to the resident. Review of the facility provided policy HCSP dated August 2012 directed a HCSP was required if a	S3170		

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S3170	Continued From page 9 resident required supervision or assistance with activities of daily living, management of medications or physician-ordered treatments. The HCSP may be updated as often as the licensed nurse responsible for the care deemed necessary, at least annual, and upon a significant change. The facility failed to revise the Health Services Plan to reflect the care and services provided by skilled nursing services and medication management for this resident during his/her spouses' absence from the facility.	S3170		